FIGURE Modification of nasal packing to improve patient comfort after transsphenoidal surgery.

ly is one of the major complaints patients have in the postoperative period. It creates patient anxiety and discomfort related to the subjective feeling of not getting enough air.

Recently we asked the surgeons to insert a properly sized nasal trumpet in one nostril prior to packing the nose, with the gauze rolls packed around the nasal trumpet, as illustrated in the Figure. The length of the trumpet is shortened such that it does not extend too far into the nasopharynx. We have used this modified nasal pack in over 30 patients undergoing transsphenoidal surgery and have not had any problems since the patient discomfort related to the inability of nasal breathing. Although respiration is probably insufficient through one nasal trumpet, the patient's subjective feeling is improved by allowing some air passage through the nose.

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Combined spinal and epidural anesthesia for major abdominal surgery in infants

To the Editor:

I was interested to read of the 'new' combined spinal-epidural (CSE) anesthesia in awake babies.¹ The technique is not new: we described it in 1994.² We

preferred this to our previous technique of epidural anesthesia through caudal catheters³ because it produced rapid onset of a dense motor and sensory block. This extended the duration of block for prolonged surgery with an advantage over often limited and sometimes short duration of spinal anesthesia alone.

Williams and colleagues have considerable experience of regional anesthesia in awake babies and it would have been interesting to set their report within the context of experience in more than 800 babies. What are the indications for CSE anesthesia and what factors are important for success? We found the technique was less successful in full-term than ex-premature babies. What determined the choice of midazolam or propofol instead of inhalational agents in babies requiring sedation? The authors describe the technique in 19 babies: did they make unreported attempts in others?

Williams reported subarachnoid placement of the caudal catheter (24g) in one of 19 babies and a subsequent total spinal. Van Niekerk reported two misplaced 23g caudal catheters in 20 pre-term babies (one intravascular, one subarachnoid);⁴ blood or CSF were not aspirated. These potentially serious complications with small diameter catheters may be relatively common. Since this report and the audit by Wilson⁵ I have used a larger catheter (external diameter 0.9mm) with 3 lateral eyes in babies > 3.5 kg in the belief aspiration through misplaced catheters is more likely.

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REPLY:

We gratefully acknowledge Dr. Peutrell's important contribution to the practice of regional anesthesia in infants. *Paediatric Anaesthesia* was not cited in most

medical databases when her work was published and several computerized searches do not mention Dr. Peutrell's work. Our work concerning the technique has been discussed widely without any of our colleagues mentioning Dr. Peutrell's work. We believe Dr. Peutrell's work is important and we shall cite her paper in a review article on infant spinal anesthesia we are preparing for publication 1999.¹ Little of this is truly "new"... Bainbridge, and later on Gray, reported on spinal anesthesia in infants around the turn of the century and by 1933, Junkin described the use of spinal anesthesia for thoracic surgical procedures in children.²⁻⁴

Dr. Peutrell's report concerned the use of this technique to perform inguinal hernia repair. In our institution, we are able to perform inguinal hernia repair in children under a single shot technique with hyperbaric tetracaine and epinephrine. The main point of our paper was to stress that major abdominal surgery in infants can be carried out without general anesthesia, endotracheal intubation and the potential need for post-operative ventilation. We use this technique for most surgical procedures below the level of the diaphragm in both premature and term infants. Our collective experience with infant spinal anesthesia now totals in excess of 1,000 cases and we have utilized the combined technique for more than 30 patients. The presence of a catheter also provides for post-op pain control.

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